STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 91020-001**

v

Blue Care Network of Michigan
Respondent
_____/

Issued and entered
this 9th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 17, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On July 23, 2008, after a review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be resolved by analyzing the Blue Care Network (BCN) BCN 10 Certificate of Coverage (the certificate), the contract defining the Petitioner's health coverage. It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner received medical benefits under an Aetna policy until her coverage was terminated on August 1, 2006 when she and her husband divorced. Petitioner began to receive coverage through BCN on April 1, 2007.

This appeal involves a series of medical claims for services received by the Petitioner from April 1, 2007 through April 1, 2008. During that period, the Petitioner received outpatient

medical services from several providers: Dr. XXXXX, Dr. XXXXX (XXXXX), Dr. XXXXX, and XXXXX. The Petitioner requested that BCN provide coverage for these services. BCN declined to provide coverage. The Petitioner appealed BCN's denial and, after exhausting BCN's internal grievance process, received its final adverse determination letter dated July 3, 2008.

III
ISSUE

Did BCN properly deny coverage for the Petitioner's dermatology treatment?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says when she filled out her BCN paperwork, she was asked who her primary care physician was and she listed Dr. XXXXX. She also asked Dr. XXXXX's office if they participated with BCN and was told that they did. She says his office even took a copy of her health card. Additionally, she asked Dr. XXXXX's office if they participated and was told they did not but that they would help her submit claims to BCN for payment. Based on this information she proceeded with treatment.

From April 1, 2007 through April 1, 2008, the Petitioner was treated by Dr. XXXXX and Dr. XXXXX based on a referral by Dr. XXXXX. The Petitioner argues that BCN should cover the cost of the treatment and consultation provided by Dr. XXXXX, Dr. XXXXX, and Dr. XXXXX because she attempted to follow the rules but was given misinformation from BCN and her providers regarding acceptance of her health coverage.

Respondent's Argument

In its final adverse determination, BCN denied the Petitioner's request for coverage saying, "you are required to use Blue Care Network contracted physicians and receive

authorization from your primary care physician for the services; therefore your request remains denied."

BCN stated that the Petitioner had not designated a particular physician as her primary care physician when she enrolled with BCN. Consequently, she was assigned a physician, Dr. XXXXX, however, the Petitioner did not contact Dr. XXXXX. (In February 2008, the Petitioner selected Dr. XXXXX as her primary care physician.) Dr. XXXXX and Dr. XXXXX are not BCN network physicians. Dr. XXXXX and XXXXX are BCN in-network providers. Treatment by any doctors other than the Petitioner's primary care physician requires a referral from the primary care physician, which the Petitioner did not obtain. Also, BCN points out that members are required to use BCN providers for care when available within its network of providers. BCN says that because the Petitioner did not comply with the requirements of the certificate, coverage was denied.

Commissioner's Review

The Commissioner carefully reviewed the arguments and documents the parties submitted. The issue in this case is whether BCN properly denied coverage for the Petitioner's services from the listed providers.

BCN, a health maintenance organization, operates through a network of providers who sign contracts and agree to accept BCN's negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefits every member. If an HMO member uses an out-of-network provider, payment for the out-of-network services may be greatly reduced or even excluded entirely by the HMO.

The certificate, which describes the Petitioner's health care benefits, includes the following provisions:

> **Part 1: Your Benefits**
>
> *** * ***
>
> ***1.04 Outpatient Hospital Services***
> Outpatient services are covered when they are medically necessary and preauthorized by your Primary Care Physician and BCN.
>
> **PART 2: Exclusions and Limitations**
> This section lists the exclusions and limitations of your BCN 10 Certificate.
> ***2.01 Unauthorized and Out-of-Plan Services***
> Except for emergency care as specified in Section 1.05 of this booklet, health, medical and hospital services listed in this Certificate are covered **only** if they are:
> - Provided by a BCN-affiliated provider and
> - Preauthorized by BCN.
>
> Any other services will not be paid for by BCN either to the provider or to the member.

In the Petitioner's case she continued treatment with her current providers prior to obtaining authorization from BCN. The services received were available from network providers but required prior approval. Although Dr. XXXXX and XXXXX are part of the BCN network, their services were not authorized by BCN.

While it is regrettable that a series of misunderstandings apparently has resulted in the Petitioner receiving care not covered by BCN, the Commissioner is limited to applying the terms of the certificate when reviewing BCN's claims denials. The Petitioner did not meet the requirements in section 2.01 for pre-authorization and use of in-network providers. The Commissioner finds BCN's final adverse determination is consistent with the terms of the certificate.

V
ORDER

Respondent BCN's July 3, 2008, final adverse determination is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner

of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.